THE MASTER'S WORKSHOP CAMP, INC.

179 Church Camp Lane
Robinson, TX 76706
(254) 662-0441

Medical Information and Permission Form

This completed form must be submitted to the Camp Health Officer at check in on 1st day of camp. No camper or staff person under the age of 18 will be admitted without a completed form signed by their parent/guardian.

Full Name: _____ Gender: M F (circle one)
First Middle Last

Social Security # of camper/staff: _____

(social security # will be used for medical emergencies only and this form filed securely in camp medical records)

Please note any physical limitations of above named that camp nurse and/or staff need to be aware of:

_____

Doctor: _____ Office # _____

IN CASE OF AN EMERGENCY:

Notify: _____Relationship to above: _____

Contact phone #:_____Alt Phone #:_____

Insurance Information: Is the person named above covered by insurance? Yes No (circle one)

If so, which insurance company/carrier? _____

Policy holder's name: _____ Relationship to above:_____

Insurance Policy #:_____ ID/Group #:_____

CAMPER MEDICAL INFORMATION:

ALL MEDICATIONS MUST BE GIVEN TO THE CAMP HEALTH OFFICER UPON ARRIVAL AT CAMP. All medication must be in the original packaging. Prescriptions must have camper/staffer's name, physician's name, prescription number, date prescribed, name of medication and directions for use. All medications, including over-the-counter will be locked up at all times. EACH MEDICATION BROUGHT MUST BE LISTED HERE. The medications listed below need to be given to above named camper/staffer at camp, at the designated time, in the proper dosage, administered by the Camp Health Officer or the Camp Director. Documentation regarding specific day/time these were administered will be recorded in the Camp Medical Log throughout the week.

RX Number	Medication Name and Proper Dosage	Administer at (circle all that apply)	Other notes
		Breakfast Lunch Bed Only as needed	
		Breakfast Lunch Bed Only as needed	
		Breakfast Lunch Bed Only as needed	
		Breakfast Lunch Bed Only as needed	
		Breakfast Lunch Bed Only as needed	
		Breakfast Lunch Bed Only as needed	

PLEASE COMPLETE BACK OF FORM

Immunizations: Place a check beside each one that is current.
DPT or Tetanus _____ Polio _____ MMR _____ Hib _____ HepB _____
Chicken Pox (or has had) _____

Allergies: List all known. Describe reaction and management of the reaction.

Medication allergies (list) — include penicillin, sulfa, and any other medications, etc.

_____

_____

Food allergies (list) — include milk, eggs, etc.

_____

_____

Other allergies (list) — include insect stings, bee stings, poison ivy/oak, asthma, etc.

_____

_____

Has your child ever had any severe adverse reaction (ie: incontinence, respiratory distress, loss of consciousness) from any insect bite or contact with poisonous plants? Yes No (circle one)

Please list any other health concerns that you would share with the Camp Health Officer or Director: _____

_____

PARENTAL AUTHORIZATION AND PERMISSION:

This health history is correct to the extent of my knowledge, and the person named above has my permission to engage in all prescribed activities, except as noted on this form. In the event that I cannot be reached in an emergency, I herby give permission to the physicians selected by the Camp Health Officer and/or Adult Leader in charge to hospitalize, secure proper anesthesia, and/or order injections or surgery for my child. I give permission to The Master's Workshop Camp for off-premises transportation as needed in case of emergency.

I hereby give permission to the Camp Health Officer or Director to administer prescribed and/or over-the-counter medication to my child as specified on this form.

Please check any over the counter medications listed below not already noted on the front of this form that may be administered as deemed necessary by the Camp Health Officer or Director either as the brand name or a generic version of it. If it is not checked, you will be contacted before we can administer these medications.

Benadryl _____ Ibuprofen _____ Acetaminophen _____ Tums _____ Immodium _____ Pepto Bismol _____

Sun burn cream _____ Sting Kill Wipe _____ Antibiotic Cream _____ Eye Drops (Visine) _____ Swim Ear Drops _____

Tecnu, Caladryl _____ Hydrocortisone Cream/Spray ____ Antiseptic Wound Spray (Bactine, Dermoplast) _____

I hereby release from liability the North Texas Association Men's Fellowship of the United Church of Christ, The Master's Workshop Camp, and/or any of its personnel for any adverse reactions, allergic reactions, or side effects from any of these medications.

Parent/Guardian Signature: _____ Date: _____